

**COMMUNITY PARTICIPATION IN
HEALTH, FAMILY PLANNING AND
DEVELOPMENT ACTIVITIES A REVIEW
OF INTERNATIONAL EXPERIENCES**

Final Report

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CONTENTS

Introduction.....	3
Statement of the Problem.....	3
Comprehensive Rural Health Project (CHRP), Jamkhed, India	6
Karnataka Project for Community Action in Family Planning (KPCFP), India	10
Community Participation Through Self- Introspection Mawas Diri: A Tool to Stimulate Community Participation	14
An Integrated Rural Health Project in Saradidi, Kenya.....	17
Mobilization for Nutrition in Tanzania (The Iringa Nutrition Project)	19
Community Involvement in Health Development: Caranavi District, Bolivia.....	23
Comilla Development Model, Bangladesh	28
Chakaria Community Health Project (CCHP), Bangladesh	31
Conclusion	35
Bibliography	38

Introduction

Family planning and maternal-child health programme in Bangladesh has achieved a commendable success in the recent past. This has mostly been achieved through a large scale service delivery system of the Government with donors' support and cooperation from non-government organizations. Currently, there are 35,000 family planning service outlets in the country, a large majority of whom are organized at district level and below. The activities are most intense at the union level and below, with 3,000 Family Welfare Centres (FWC), 1,275 Rural Dispensaries, and 23 Mother and Child Welfare Centres (MCWC). At the village level, basic MCH-FP services have been provided by the FWC staff at satellite clinics at the rate of 30,000 clinic days per month. Additional services at door-step have been provided by 23,500 Family Welfare Assistants (FWA) of the Government and over 8,000 field workers of the non-government organizations.¹ The urban areas are mostly devoid of any effective and organized service delivery systems from Government and non-government organizations.

Statement of the Problem

While the level of success as measured by increased acceptance of modern methods of family planning and MCH services is improving every year, relevant quarters are concerned about the programme, its financial and social sustainability. The massive infrastructure developed over the period is mostly maintained with donors' support. It is apprehended that external support at the current level may not be easily available. The other major issues in this context include achievement of a replacement level of fertility within a stipulated period and improvement of quality of MCH-FP services. It is widely believed that most of the concerns will be taken care with an effective community participation.

The importance of community participation in MCH-FP programme has also been underscored in the USAID strategic options proposed for the period ending in 2005.² In attaining the visioned objectives a series of institutional and programmatic components have been identified. The major components include social institutions and educational programmes, and decentralized health system. Involvement of the community in some form or other has also been outlined in the report to address the above two components.

While there is little scope to argue to the contrary, it is clear that there is a lack of understanding about how community participation can be ensured. What will be the

¹Haider S. H., Streatfield K. and Karim M. A. 1995. Comprehensive Guidebook to the Bangladesh Family Planning-MCH Program. Research Evaluation Associates for Development (READ), The Population Council, Ministry of Health and Family Welfare, Dhaka.

² Pinkham F. *et al.* 1995. The Bangladesh Family Planning and Health Services Project: Strategic Options Report. USAID (RFA-USAID/Bangladesh-96-p-002).

degree of participation? Participation in what aspects of the programme? What will be the relation between the programme and the community?

The theme of community participation has been incorporated in the agenda of the Government and non-governmental organizations, in the context of primary health care, since the Alma Ata Conference and it was defined as one of the pillars of primary health care. Despite some attempts in Bangladesh, the success has so far been limited.

In the context of MCH-FP programme, community participation has so far been attempted through involvement of the representatives of the local government or non-traditional groups/committees created by either Governmental or non-governmental organizations.³ Though the community members participated in such initiatives, their role is limited since the control of the programme in terms of resources, planning, implementation, monitoring and evaluation always held by the staff of the implementing agency, be it governmental or non-governmental.

Another aspect of the current strategy for ensuring community participation is based on the assumption that the programmes initiated with external support will, after sometime, be left with the community for operation. There has been little evidence to lend support to this assumption. Moreover, the tradition in this culture is just the opposite.

The Chakaria Community Health Project of ICDDR,B has been an exception where attempts have been made to activate the indigenous village-based self-help organizations to take health initiatives. The project has so far succeeded remarkably in mobilizing community to define, plan and implement health actions with virtually no material support from the project.⁴

The task of ensuring community participation is a challenging one and deserves special attention. A mere invitation to the community members for participating in a programme brought in by outsiders is very simplistic and ignores the complex issues like social psychology, culture, and various other social issues. Bangladesh has a long tradition of community initiative in establishing schools, building roads, markets, mosques, etc. Most of the now nationalized schools were once built through community initiatives and were used to be maintained by the community. Even now most high schools are managed by the communities. There has been over 6,500 registered village-based voluntary organizations engaged in various welfare activities in the country.⁵ It is reasonable to

³Committee at union level has been one such example. USAID-supported local initiative project which has made significant impact on family planning acceptance in rural Bangladesh, also falls broadly under this category.

⁴ Bhuiya A. 1996. Rethinking community participation. I: Health initiatives by indigenous self-help organizations in rural Bangladesh. (Manuscript), ICDDR,B; Dhaka.

⁵Government of Bangladesh. Directory of Voluntary Social Welfare Organizations in Bangladesh. Bangladesh National Social Welfare Council, Dhaka. Bhuiya A. 1996. Characteristics of village based self-help organizations in a rural area of Bangladesh. Manuscript, ICDDR,B; Dhaka.

think that community participation can be initiated for health and family planning related activities.

Thus, it is worth to carry out action research in this regard to find ways to:

1. activate community initiatives to improve maternal and child health and family planning status;
2. establish a link between the community initiatives and the relevant public and private sectors;
3. ensure cost sharing by the community members in MCH-FP activities.

Before designing any action research to fulfill the above objectives, it was considered appropriate to review various programme models, preferably on health and family planning, with a reasonable level of success in community participation. Thus, a literature review was done during July-October 1996 with the objectives of identifying a range of models used for increasing community participation and their experiences in terms of implementation, management, financing, monitoring and evaluation, and sustainability in both rural and urban areas. Attempts were also made to identify set of indicators to assess the level of community participation in these programmes. The present report documents the results of the said review.

The review was done on the basis of literature available in POPLINE and MEDLINE databases and other materials available in Dhaka. The search for literature was carried out by using appropriate keywords to achieve the review objectives. After a preliminary reading of the material, it was categorized on the basis of five dimensions. The dimensions included the extent of community participation in (1) initiating the project, (2) needs assessment, (3) defining, planning, and implementing actions, (4) monitoring and evaluation, and (5) resource mobilization. The best eight projects that scored high in terms of the above were reviewed extensively. However, all literature scanned in connection with the review have been listed in the bibliography.

The eight projects thus selected were:

1. Jamkhed Comprehensive Rural Health Project (CHRP), India
2. Karnataka Project for Community Action in Family Planning, India
3. Integrated Rural Health Project in Saradidi, Kenya
4. Mawas diri Community-based Health Care Systems and Training Programme, Indonesia
5. Mobilization for Nutrition in Tanzania

6. Community Involvement in Health Development: Caranavi District, Bolivia
7. Comilla Development Model
8. Chakaria Community Health Project of ICDDR,B, Bangladesh.

A brief description of all the projects with their salient features is presented below:

Comprehensive Rural Health Project (CHRP), Jamkhed, India

The project is located in Jamkhed in the Ahmednagar district of Maharashtra state and began in 1971. It was initiated by an Indian couple with background in surgery. One of the major goals of the project was to provide health services appropriate to the conditions of rural life and draw on locally available resources to the maximum extent possible.

The project made tremendous positive impact on health of the population by reducing the incidence of chronic diseases, leprosy, tuberculosis, and malaria. The acceptance of preventive public health measures and adoption of appropriate health behaviour has improved resulting in substantial decline in mortality. Among others, the project activities also have contributed in improving the position of women and poorest segment of population, and generated self-reliance among the villagers. The project was also very successful in developing village based organizations to play active role in all aspects of development including health.

Over the period the project changed its role by reducing the intensity of the inputs and currently playing the role of a facilitating organization in maintaining network among the village-based organizations. It is claimed that the activities have been maintained by the village-based organizations even after reducing the project inputs.

Initiation of the Project

The project was initiated by individuals from outside the project area. At the beginning, the founders were contacted by one of their friends from the locality, who knew them for quite sometime. He could mobilize local people to show that the project will be welcomed by the community and all possible supports will be provided. This was possible because of the reputation of the couple and the need for curative health services in the area. The community members expected that a good health service facility will be established in the area from which the community will be benefited.

Process and Level of Community Participation

The project activities started with a curative service facility which was established with material support from the community. The community members started to get benefit immediately. As the process went on, it was realized that the marginalized low-caste community members were not receiving the most out of the project. It was also difficult to bring them together with the high-caste and rich members of the community.

Attempts were made to identify any activities carried out by people of various castes and socioeconomic groups. Volleyball game was one such activity. By using the example of the game and mass participation in it, a proposal to form Farmers Clubs (FC) and a women organization, namely, Mahila Mandal (MM) was made. Eventually, many FCs and MMs came into existence. The members of the FC and MM were supportive of the services provided by the health workers of the CRHP. They helped in disseminating health messages and in mobilizing the community for development efforts.

Leadership and Decision Making

There were no formal links between the project staff and various village groups, such as farmers clubs and women's clubs whose formation was encouraged by the project. The villagers provided land and other supports for building the facility at Jamkhed. The Project Directors offered advice, if requested, but the initiatives and the decisions taken have been reported to be the sole responsibility of the club leaders.

Although there are no formal ties with the Government, the project actively sought the cooperation of all the government agencies in the area, and had established an excellent working relations with them.

The Village Health Worker (VHW) became a major link between the project and the community. The VHW proved to be a great help in generating community involvement. This was facilitated by her, she being a resident of the village.

The choice of activities undertaken under the project was made through a continuous dialogue between the project staff and the villagers. Special efforts were made to ensure that the views and needs of the poorest members of the community would also be heard. As the workers gained credibility, the people became more open.

Activities

The project activities can be divided into two broad categories:

1. **Health and family planning:** Simple primary health care, care of expectant and nursing mothers and birth delivery, care of pre-school children, control of chronic illness (leprosy and tuberculosis), prevention of blindness, treatment of physically

handicapped, follow-up and treatment of emergencies and family planning side-effects;

2. **Development activities:** Income-generating activities to relieve economic pressure during seasonal unemployment or under-employment, provision of improved animal health care and alternative sources of energy, such as wind, solar, biogas, and arranging non-formal education.

Financing

Funding for the capital costs at the beginning was provided by a missionary group. The local community donated land, building material and manpower, representing some fifty percent of the total capital cost estimated to be US \$ 140,000. As regards operating cost, it was made clear at the outset that the health services, unlike free services from the government hospitals, would be provided on a “ fee for service” basis. The charge would depend on the economic condition of the patient. This arrangement was generally accepted, and often community members collected money to cover the cost of chronically ill patient needing costly surgery. It took four to five years, until credibility was established, for the health services to become virtually self-supporting, during which time, the project received funding from outside private sources. The amount of income from various sources, including fees from patients was sufficient to cover the core budget of the health care offered by the project. The biggest element of the operating cost was its mobile services. The project needed outside funding support to run its credit operation for income-generating activities.

Special Feature

The activities of the FCs and MMs on primary health care were unique in India. These organizations were supportive of the services provided by the health workers and helped develop self-reliance among the community members in health and other matters. They also helped in the spread and acceptance of new ideas and technology. The club members and the project staff worked together, planned and carried out programmes which benefited the members as well as others in the village. It was through these clubs that the community got involved in the health programme. The volunteers of MM and FC played an important role in decreasing the level of superstitions, changing attitudes and teaching good health habits, encouraging small family norms, motivating other villagers to form clubs like theirs in addition to the health-related activities. The volunteers were involved in many educational, agricultural and economic development programmes by way of organizing non-formal educational programme, mobilizing and organizing women to get bank loans to start self-employment schemes and take collective responsibility for its repayment.

Achievements

The project has been operating more than 15 years. Its directors summarized its achievements as follows:

“Project villages have been remarkably successful in reducing the incidence of chronic diseases, leprosy, tuberculosis and malaria. Timely detection and treatment of illness, and preventive measures such as immunization for children have effectively improved the health status of the villagers. There has been a marked decline in infant mortality to less than 40 per 1000., compared to the State average 110. There has also been a sharp decline in maternal mortality and morbidity. The crude birth rate in the project villages was around 25 per thousand population, compared to 30 per thousand for the State as a whole. It had also contributed in improving the position of women and the poorest member of the community, and standard of living among the beneficiaries and promoting self-reliance in the community. A study on the FCs and the MMs revealed a significant positive role of such organizations in the rapid spread and acceptance of new ideas and technology in the community.”

Success Factors

One of the important factors for the success of the project has been the creation of the FCs and MMs. These were the means of organizing communal support for the project and of channeling the energies of the people to find their own solutions for their problems. The development of confidence in their ability to solve their problems jointly has been a major outcome of the project and was crucial for achieving self-reliance.

In addition, the personalized attention given throughout by the project directors at the individual and at the community level was also very important. Other factors included:

- Local support;
- Good- will generated among local people;
- Local involvement and their acceptance to pay for curative service;
- Flexibility in planning and implementation in response to constant evaluation;
- Simplification of technical and administrative procedures;
- Freedom from intervention by outside agency.

Obstacles

Attitude of non-cooperation from the indigenous medical practitioners was the main difficulty faced by the project. These practitioners were feeling threatened by the project work. This was overcome by virtue of the confidence the project earned from the community members.

Sustainability

Through the work at Jamkhed, many communities, especially those with active Mahila Mandals (MM) have become self-reliant. As reported they depend on CRHP only for secondary and tertiary technical support and networking. Since 1989, CRHP has been gradually withdrawing, because many of the community organizations have become self-reliant. Many Mahila Mandals are functioning well and mobilizing resources on their own. They organize health camps and continue to monitor the health of children in the village and carrying out many income-generating activities. They work closely with the government ANM (auxiliary nurse midwife) to ensure the maternal and child health.⁶

Karnataka Project for Community Action in Family Planning (KPCFP), India

The project began in 1979 with focus on family planning and maternal and child health. It was derived from an earlier project on awareness development which was, in fact, started in 1974.⁷ During the first phase the project focused on educational and social and development activities. In its second phase from 1979, the project aimed at increasing community participation in family planning and MCH. The project was implemented by the Family Planning Association of India (FPAI) in Belgaum, a division in the northern part of the State of Karnataka covering a population of nearly 250,000 living in over 150 villages. A second revision of the project activities was made in 1983 with increased emphasis on establishing and strengthening local institutions. The project made significant improvement in family planning practices and in attaining self-reliance by the villagers in planning, implementing and financing community activities.

The project followed a three-stage process. The first stage was the action by the FPAI alone followed by the second stage in which the community took action in collaboration with FPAI. In the third stage, the community members took their own initiatives by themselves.

Objectives of the Project

The three main objectives of the project were to:

⁶ Arole M. and Arole R. 1994. Jamkhed: A Comprehensive Rural Health Project, Macmillan Press Ltd.

⁷ Wolfson M. 1987. Community Action For family Planning, Development Center Studies, OECD, 1987

- increase community involvement and support for small family norm through education and social and developmental activities;
- increase family planning acceptance;
- improve MCH programme to support family planning and promotion of women activities and child care;
- help community to develop skills in planning, implementing and sustaining self-help activities, based on their felt needs.

Organization

The activities were carried out by a large number of intensively-trained professional staff. The members of the staff were directed by a three-member liaison committee of the volunteers appointed by the FPAI Regional Office in Dharwad, a university town near Belgaum. Both volunteers and the project staff were guided by the FPAI National Headquarters in Bombay.

There were 13 administrative and supervisory staff at Dharwad. The six field units in each of the six villages were manned by four community welfare workers (two men, two women), a field organizer and an auxiliary nurse-midwife(ANM). Each unit was supported by an honorary medical advisor who was a local private practitioner. A change in the project strategy was made in 1983 which resulted in a reduction of personnel from 84 to 61, and the community welfare workers were moved from headquarters to the villages with a view to strengthening the community endeavours.

Local Voluntary Groups (LVGs) constituted the backbone of the project. They provided the structure for enabling the community to take action to deal with their various development needs, including family planning practices. The process of forming LVGs was extended in almost all the project villages. The most commonly formed groups were youth clubs (Yuvak Mandels) and women's clubs (Mahila Mandels), followed by elders' clubs, cultural clubs, and farmers' fora.

Project Implementation

The educational activities, the core function of the project, were initially carried out by the project field staff, and later by the project staff and the LVGs together. As the project progressed, the LVGs took full responsibility both for planning and carrying out most educational activities. The various activities carried out under the project included mobilization of the community by way of formation of voluntary groups; training of group members; and carrying out activities by the trained group members.

Relations with the Government and Voluntary Agencies

There was a good cooperation between the project and government departments, particularly with the staff responsible for the PHCs. The relation with the government staff was considered very important and complementary in the work and also to ensure sustainability of the programme after the project ceases to operate. To help establish good rapport and liaison with the health staff, a series of meetings were held between the FPAI and the Government at different levels. Initial misunderstanding, especially at the field level, was gradually overcome, and the government health workers later recognized that the project supported their work. The arrangement worked well for both sides: the contraceptives required by the project were provided by the PHC, and the project helped the PHC with other medical supplies. Camps for immunization, IUD insertion and sterilization were organized jointly by the project and the government staff.

In the early days of the project, the Government of Karnataka passed a formal order agreeing to its implementation. This has facilitated cooperation of the government departments responsible for development activities, such as the Block Development Office, Agriculture, Education, and Women and Child Welfare, and the LVGs.

The project has made successful efforts in identifying non-governmental bodies of all kinds that could be helpful in keeping the project going and in expanding its activities. Useful working relationships had also been established with the state Adult Education Council, the Rotary Club, the Lions Club, the Indian Medical Association, etc. that helped organize many coordinated activities, notably health campaigns and camps to address special health problems. The project had also been effective in securing the cooperation of the local religious committees existing in most villages.

Achievements

Between 1979 and 1984, the total number of LVGs rose from 131 to 454 and the number of members from 3,000 to 16,000. In 1984, sixty percent of the MCH sessions were organized by the LVGs alone, and nearly 40 percent jointly with the FPAI. The community played a still more active role in the area of family planning-- both family planning education and provision of services. Trained community leaders motivated the couples to accept the small family norm and to use contraceptives. The educational activities, initially which was entirely the initiative of the project staff, had later been increasingly planned and carried out by the LVGs. It was also found that the average attendance at educational activities carried out by the LVGs was consistently higher than that of the FPAI-conducted sessions. One of the most significant achievements was that more than one-third of the project villages became self-reliant in planning, implementing and financing community activities.

Financing

The project had various sources of funding : the FPAI; the Government and other agencies; and the LVGs. It was the intention since the outset that the FPAI support would be gradually phased out, and to be replaced by the resources generated by the community members themselves either from their own resources or from outside. For the five-year period (1979-1984), the own input of the communities to their activities under the project, made through the LVGs, was higher than that of the FPAI. This testifies the ability of the KVGs to assume an increasing share of cost of the community activities, partly from their own resources and partly by securing Government or other support. By 1984, the LVGs and the Government were contributing roughly an equal amount.

Principal Positive Contributory Factors

The existence of the population awareness project in the area undoubtedly facilitated an easy start of the project and shortened the length of the preparatory phase. The FPAI had acquired considerable knowledge of the area, the people and their customs, perceptions and needs, and their potential for organizing themselves to improve their situation. Harmonious relationship among the different ethnic and religious groups in the political sphere assisted the development of a community spirit.

The relocation of the community welfare workers from taluk headquarters to the villages strengthened the relationships between the project and the communities, and enabled the project staff to become more familiar with local needs and problems. The incorporation of modern ideas into traditional forms of entertainment provided a convenient way for the project to get its ideas across to the community.

Problems Faced by the Project

The following problems were faced during implementation of the project:

- The undemocratic social structure and practices in the villages made it difficult to get the participation of the very poor and the lower castes;
- The low status of women and their limited involvement in social activities hindered their participation.
- The lack of planned and sustained efforts on the part of the LVGs to mobilize local resources hampered the community activities.

Sustainability

It was not clear from the document whether the FPAI inputs were totally withdrawn from the area and its consequences. Thus, no clear judgment could be made about the level of

sustainability of the activities. However, it is likely that the skills acquired by the local organizations in needs assessment, identification of solutions, and implementing programmes with local resources will remain with them and will be useful for any community initiatives in the future.

Community Participation through Self- introspection Mawas Diri: A Tool to Stimulate Community Participation

The Indonesian Department of Health took this initiative to design a participatory monitoring tool with an aim to alleviate health problems through effective community involvement. A local NGO was entrusted to do the job in 1984. The approach proved to be effective in ensuring community participation⁸.

Goal

The basic goal of the *Mawas Diri* tool was to ensure community involvement in solving community health problems and to achieve overall community development.

Intervention Strategy and Implementation

The approach was based on a problem-solving cycle which began with the detection of a problem by the people themselves and went through the steps of identifying solutions, taking actions and evaluating effects on the problems.

To facilitate the programme the people developed a simple self-survey form which listed the various aspects of life related to their family and community health welfare. These aspects included a healthy environment, a healthy way of life and healthy socioeconomic conditions. A healthy environment covered the home and the outside yard. Issues within the home included provision of light, floor, ventilation, roof, and cleanliness. The household environmental issues included drainage, garbage disposal, animal and pets, and plants. After the indicators were developed, a minimal standard was set for each component to classify a condition as good or not good. Equipped with the form, trained village workers (VHWs) visited a specified number of families in their neighbourhood, usually between 15 and 20. They evaluated each item on the form using a simple score of 'good' 'not good', and 'not relevant' whether a home and its environment met the predominant standards. After visiting all the families the forms were processed. Each data collector added up the total number of 'good' (G) and 'not good' (NG) families he had visited to make the problems evident.

The next step was to discuss the three most common problems for future actions. To decide which three of the problems to tackle first, the seriousness and extent of the problem and the capacity of the community to solve them by using local resources were

⁸ Johnston, M. 1990. Mawas Diri: a tool to stimulate community participation. *Health Policy and Planning*. 5:161-166

taken into consideration. Data were collected every three or four months and compared with data from the previous three months. If the number of 'not good' decreased it was determined that some progress had been achieved.

Achievements

The *Mawas Diri* tool had proved attractive to a diverse group of people including mid-level policy-makers, village officials, government technical services and VHWs. Through this tool a village can collect its own data and use it to draw up realistic plans for development. This can help overcome a major problem in the Indonesian planning process in which villages are encouraged to submit their own plans for funding. The process also motivates the community to tackle creatively the problems which they themselves detected. The approach also had possibilities for promoting institution-building by strengthening the functions of the local bodies. Government technical services said that *Mawas Diri* could assist them in a number of ways. The data and prioritization of problems provided them with specific information on the location and extent of problems in a certain area. It assisted them in their planning activities, and it enabled them to make more effective allocation of funds and facilities in government programmes. The *Mawas Diri* approach proved that community participation is not only possible in all stages of a development programme but also increases the quality of activities and contributes significantly to human development. Through the *Mawas Diri* approach people gain skill in looking critically at their environment, detecting problems and prioritizing them, in planning, implementing and monitoring improvements. Through this process the people develop initiative and creativity. Most important of all, by this working programmes people work in their choice, gain greater confidence in their right and ability to control their lives.

Community Involvement

The community was directly involved from the beginning since the *Mawas Diri* survey form was designed by the villagers in cooperation with a health or community worker. It was the community members who selected the aspect of life, component, and indicators to monitor. Lively and lengthy discussions usually took place when the form was designed. They had developed a strong feelings of mutual responsibility and commitment during the process.

Leadership and Decision Making

The meetings were facilitated by the villagers with assistance from the project staff. However, the definition of the actions and their implementation was determined by the villagers themselves.

Relation with the Government

The *Mawas Diri* tool was implemented by the request of the Indonesian Department of Health with the help of YIS a non-governmental organization which was involved in community health and development. This support was helpful in achieving success.

Special Feature

The unique feature of the *Mawas Diri* tool was that the problems which can locally be solved were selected. Thus, the solution of the problems had minimum dependence on external resources. The external assistance was mostly limited to the introduction of the participatory monitoring system. The process was also successful to generate community interest in solving their own problems by themselves which was itself an empowering process for the community members.

Financing

The Indonesian Department of Health and the Australian International Development Assistance Bureau funded the programme. There was no significant attempt to raise funding with a view to sustaining the activities after the closure of the project.

Factors Contributing to the Success of the Project

The involvement of the community members from the beginning was an important factor in making the project a success. Identification of the problems by the villagers and finding a solution by themselves were also important. The implementation of the action and the monitoring of the progress by the community in a regular basis played a key role in making the programme a success.

Obstacles Faced by the Project

One of the problems faced was the reliance on literate people who could fill the form and who could work with numbers. Another problem was to maintain the routine in collecting data and enthusiasm of the community members.

Sustainability

Village heads considered that the tool can help them obtain reliable and relevant data as well as motivate the community to tackle some of their problems. It was not clear how long the activity would have been maintained after the closure of the project.

An Integrated Rural Health Project in Saradidi, Kenya

The project was initiated in 1979 as a self-help for health and development by the community members in Saradidi, Kenya, in response to the problems faced by the community.⁹ The activities included health and income-generating activities. The activities were carried out with material support from within and outside the locality. The project was still running 10 years after the beginning more or less on its own. The project believed to have contributed in reducing mortality by controlling malaria and other immunizable diseases.

Goal

To provide the target group with basic health services that would be appropriate to the conditions of rural life and draw on locally available resources including community participation to the maximum extent possible.

Intervention

The programme ensured simple drugs to be available to the people and provided preventive and and promotive health services backed by health education. The income generation was mainly agriculture-based. The programme was based on church congregations. The project introduced village health committee and village health helpers to implement the project activities.

Rapport Building and Communication

The church group took the initiative to mobilize the whole of the surrounding community to be involved in health and development activities. In 1979, they selected 13 people who were given the task of taking the activities to other church congregation, denominations, and other readers. They did it so effectively that within three months most people became aware of what was being planned and their role in it. The first community meeting was open for all members of Saradidi community where the problems facing the community and their possible solutions were discussed.

Financing and Sustainability

Interventions and support from outside SRDP was significant. The programmes were dominated by external resources resulting in a weak role of the community members. Thus, the prospect of self-reliance remained bleak. Any plan to generate own resources from the community to sustain the activities after withdrawal of the project was not apparent.

⁹ Kaseje, D. C. O and E. K. N. Sempebwa. 1989. An integrated rural health project in Saradidi, Kenya. *Social Science and Medicine*, 8:1063-1071

Decision Making

The moving force seems to be the community itself. The Saradidi community is involved in the decision making processes regarding all the activities taking place in Saradidi. For example, The community is informed about the type and duration of research project in the SRDP. If a researcher fails to explain the work to be undertaken in lay language, that may be the end of the research, and at least two projects were never completed.

Programme support from the community has included voluntary leadership groups with the power to hire and fire project workers for any reasons ranging from perceived lack of commitment to the ethos of SRDP to mismanagement of project activities and resources. Existing (government) administrative leaders have effectively been part of project management. Other leaders have come from among church groups and ordinary village folks.

Lessons Learned

All the external inputs had their side-effects on programme operation and management as each donor imposed peculiar demands impinging on overall programme activities and thus on goal attainment. The FPIA, for example, pushed for intensified promotion of family planning, using the number of new acceptors, as the measure of programme success. Awareness created in the process was not considered an imbecile measure.

Funding from donors requires increasing details of data to justify further support. Quite inadvertently, the purpose and attention of the project was often diverted considerably. For example, reporting on utilization of funds (project implementation) accounted for a disproportionate effort of the director. Yet this is a major requirement of many donors as a condition for further funding.

From 1980 to 1983 there was a large turn over of volunteers whose interests and influence were generally supportive of the SRDP concept. The volunteers brought their own peculiar ideas which were strategic. Sometimes the volunteers were like unguided missiles attempting to bulldoze the community to certain preconceived directions.

Tensions between the community and the volunteers were not uncommon during 1980 to 1983. The project director's inability to harness the interests of the volunteers and the researchers did not help reduce the tensions.

Among the most noticeable failures was the spring protection schemes. Saradidi suffers from a chronic water shortage and contamination which partly explains the prevalence of waterborne diseases. However, 'appropriate' water technology experts received little community support. Some protected springs mysteriously dried up or were inadvertently blocked. Predictably, the community developed little confidence in the experts. It had

been assumed that the mere shortage of clean water would be a rallying point for spring protection in the villages. As it turned out, there was little enthusiasm.

It had not been foreseen that a protected spring would be thought to be a potential benefit to any one village as it previously served the villages around it. Parenthetically, on their part, the technical experts diligently relied on their technical know-how and left the community unconvinced. In this case the technology was apparently appropriate, but lacked the necessary mark of approval of the benefiting community.

In terms of PHC development the lesson that emerges from the SRDP experience on project formulation was that a viable PHC project must include the community as a central entity. In the formulation of PHC project and programmes, the lesson is that the project must be within the context of communities expected to benefit or served.

Mobilization for Nutrition in Tanzania (The Iringa Nutrition Project)

The project was launched in 1983 with an aim at understanding and addressing the problem of malnutrition in Tanzania. The major intervention components included food production and conservation, feeding practices of young children, day care centres, water supply and sanitation, and support to household and village institutions in relation to the above. The project followed the triple 'A' (Assessment, Analysis, Action) approach. The Iringa approach was a combination of goal-oriented, normative, top-down advocacy and social mobilization and empowerment of people for bottom-up actions. The programme resulted in improvement of the nutritional status of children and ensured community participation in the activities.¹⁰

Goal

The project aimed at reducing infant and young child mortality, ensuring better child growth and development and improving maternal nutrition.

Implementation and Strategies

The INP utilized existing administrative structures, starting at the regional level and involving districts, divisions, wards, and most peripherally, 168 villages. The activities were initiated and coordinated by the village Health Committees, answerable to the village council, comprising the village Chairman, Secretary and other individuals chosen by the Council. Full time government administrators were entrusted with the responsibility of coordinating and ensuring access of these nutrition committees to the various sectoral resources, both human and financial, such as extension workers from the

¹⁰ Jonsson U., Ljungqvist B. and Yambi O. 1993. Mobilization for nutrition in Tanzania. In Rohde J., Chatterjee M., Morley D (eds), *Reaching Health for All*, Oxford University Press, Delhi, pp.185-211

departments of health, agriculture, community development and education. A National Steering Committee with representatives from the prime minister's office, the line ministries, the nutrition centre, UNICEF and WHO provided overall policy guidance. These functions were eventually delegated to the regional steering committee at Iringa and later to other regions which took up this approach for development.

The proposed programme had 11 projects, and 38 sub-projects including support to the health sector, environmental health-hazard control, education and training, child care and development, technology development support, household food security, food preparation, communications, monitoring and evaluation, and research and management. A 220-page plan of operations outlined all the activities in detail. The central piece of the programme was community-based growth monitoring in which each village would conduct a quarterly nutrition assessment day. Political support ensured large levels of participation in the measurement of children's nutritional status. There was also high participation in the related analysis of the findings and community discussion of actions to be taken to improve nutrition as well as to resolve other problems identified. The 'Triple A cycle' -- Assessment, Analysis and Action became the hallmark of the INP. It described the procedure followed at each level: household, village, ward and district in dealing with the issues emerging from the three monthly assessment procedure. The community actions that emerged ranged from capital-intensive infrastructure projects, such as piped water or construction of health centres to income-generating activities, establishment of childcare centres and a host of agricultural, animal husbandry and environmental interventions.

Social Mobilization

High-level political support and action was the hallmark of the programme from the outset. The INP was launched in December 1983 by the then Prime Minister who spoke for nearly one hour to a gathering of thousands of people in a stadium in Iringa town. The inauguration was itself a major act of social mobilization. It was followed by mass meetings in each of the INP villages facilitated by trained workers, and the screening of a carefully made film "The Hidden Hunger." The film highlighted the wide prevalence of invisible or hidden forms of malnutrition and the major underlying causes. It was shown in each of the 168 villages before the first scheduled 'health day'. The health day was a regular quarterly occasion during which all children were weighed, immunizations provided and ORT demonstrated. On this day, extension workers described and discussed alternative intervention responses to the village-wide growth monitoring results. More than 1000 leaders were trained, and politicians from the village to regional levels were taught how to analyze the causes of malnutrition and the options for action at their levels. The "Triple A" approach was emphasized in the training. Following the initial village orientation, two volunteers were trained as temporary village health workers (VHW). They learned how to conduct growth monitoring and record growth information.

After the crash training programmes in each village and the initiation of health activities, village day care centres were established.

Feedback to the Community

The community-based growth monitoring activity served to focus attention on the nutritional status of children. It also provided villagers with a tool to examine their nutritional problems. It was also the basis for an information system which was used for motivating and activating higher levels of the Government to take action at the community level. The system was primarily motivational. Programme activities were measured in terms of their nutritional impact rather than simply as 'inputs'.

The village weighing days, often held monthly, were attended not only by all children and their mothers but also weights were charted and subsequent home visits were made to each undernourished child. Group sessions on health and nutrition education were held and mass services, such as immunization, demonstration of ORT, treatment of malarial fever, were provided by health workers from nearby dispensaries. A simple one-page report subbed quarterly to higher levels described the weight-for-age of all participating children and reported on any deaths occurring in the previous quarter along with the presumed cause. Of even greater importance was the written record of actions being taken at the village level. The minutes of village meetings decried requirements from government sectors at higher levels. They represented an on-going dialogue from the village to higher levels of all participating ministries.

Achievements

The INP was evaluated in mid-1988 by a team of experts. Severe malnutrition had declined from 5 per cent to below 2 percent, and overall under nutrition had declined from 50 percent to about 37 percent. A fall was seen in severe malnutrition in all expansion areas. Process assessment showed that 85 percent of mothers fully understood the growth chart and were adhering to suggested child care practices such as frequent feeding.

Special Feature

The uniqueness of Iringa as a nutrition improvement effort lied in the development of the process rather than in any particular element of the project. It was an understanding of the Triple A process that will determine how the project's success can be transferred to other situations and conditions. The growth monitoring activity is ultimately a communication strategy operating at all levels from household through village and upward to the region. It facilitated communication between mothers, with village leaders and other personnel, government resource persons and political leaders. The attention to malnutrition and health of children, enabled by the INP information system, brought all levels into a common communication relating to these issues.

The attention of the INP to the measurement of nutritional status and the repeated assessment and charting of growth started as a strategy to mobilizing communities. Thus,

third-degree malnutrition was characterized as a condition next to death. Regular weighing of each child was possible, and villages could see progress even if they could not measure fall in the rates of mortality. The visualization of growth on the weight card was a tangible means for mothers to see the effect of their own actions. The fact that villages could organize and sustain this monitoring activity on a regular basis was an indication of the independence this project engendered and a key element of its success.

Financing

Expansion of the INP experience began as early as 1985 with modest funds from UNICEF and donations from abroad. Under the guidance of the National Coordinating Committee for Child Survival Programmes and the Planning Commission, additional regions in Tanzania were encouraged to formulate programmes. Resources were mobilized from the National Treasury and from abroad. The World Bank, EEC, IFAD, NORAD, SIDA, and ODA had supported the expansion of the programme. It was expected that the entire Republic of Tanzania will have adopted the 'Iringa Approach' by 1995-96.

Community Participation

Almost all important aspects of the INP were characterized by a high degree of participation. A study that compared four well-known nutrition programmes on the basis of eight programme elements that would benefit from community participation found that Iringa scored the highest overall and in each element separately.

The application of the "Triple A" strategy was identified as the key to the good progress of the INP. This approach was fundamentally participatory and empowering for households and communities. It resulted in a greater mobilization of local resources. For example, the establishment of centres to care for young children, financed by the communities, was the result of such participation. Another tool was growth monitoring which was also a source of information used in community level discussions and decisions. Thus, growth monitoring played a role in social mobilization and enhanced participation. This gradually created an articulated demand by the communities at the higher administrative levels of society i.e. districts and region.

The participation that the "Triple A" strategy invoked, in fact, went beyond the involvement of communities in project implementation. It created an environment in which outsiders were accepted and allowed to participate in programmes designed and owned by the communities. This was somewhat different from which usually prevailed, where the community is expected to participate in activities designed and directed from outside.

Community Empowerment and Self-reliance

Local level project management was achieved during the expansion phase of the project. Individual situation analyses were done and the programme was expanded to cover the entire Iringa region, with some 450 new villages added to the original 168. The addition of 150,000 children to the programme was managed almost entirely by the existing staff with very little outside support. Recruitment of health workers, establishment of the village-based monitoring system and provision of some key health services, such as immunization and ORT, were undertaken.

It was not clear how much self-reliant the community members became in relation to maintaining activities to improve health and what might have happened after withdrawal of the project activities. It was claimed that community ownership was never seen to be in conflict with the Government. A deliberate effort was made to strengthen and establish linkages between the communities and the Government. Just as communities need to feel ownership of community-level interventions, the government needs to feel ownership of the community experiment. This occurred at Iringa, facilitating expansion, replication, and sustainability.

Community Involvement in Health Development: Caranavi District, Bolivia

This was an experimental project carried out in the district of Caranavi from 1986. The project was based on the assumptions that the existing professional staff at the district level was not enough to extend health care within the district and that the only way to have this achieved would be through involvement of local people in the health service. The approach to community participation was seen in terms of local-level collaboration with the existing services and of the assumption by local communities of a greater responsibility for their own health care. The project began with external funding and did not sustain. Nevertheless, the experiment provided invaluable experience for those who are interested in community participation.¹¹

Project Philosophy and Implementation

The project was conceptually based on a new approach to health announced in 1983 and was carried out by the district health authorities with external financial support. The new approach argued for the need of a more effective regionalization of existing health services, with health priorities based upon primary health care, and mother-child and environmental health. It was pointed out that Bolivia had an enormous richness and tradition of popular organizations (e.g. workers' and peasants' unions, and neighbourhood

¹¹ Oakley, P. 1991. Community involvement in health development, Carnavi district, Bolivia. In O'Klay, P., et al. eds. *Projects with People: The practice of participation in rural development*. Oxford & IBM publishing Co. Pvt. Limited, Geneva, pp. 145-157

and community associations) and that these organizations could be involved in future health development to achieve community participation. The approach laid great emphasis upon the concept of participation and proposed to structure organizations which would allow effective people's participation in health development. To fulfill this a set of People's Health Committees (PHCT) was formed at various levels of health services with a central committee at the national level.

In the first instance, this new health strategy established the following two basic priorities as a means of giving some immediate direction to future health development:

(a) an immediate programme of massive popular mobilization for vaccination campaigns, e.g. polio. Nationwide campaigns were launched and used as the means by which people could be brought into health activities;

(b) the structuring of people's participation and the setting up of a nationwide structure within the health service which would facilitate people's participation. The basis of this was the People's Health Committee.

In terms of the implementation of the above approach, there were two main lines of thought :

- to strengthen the existing health structure, with emphasis upon its regionalization and more effective coordination among its different levels and departments; and
- to strengthen the means of people's participation.

Management

The central objective was co-management of the health service between health professionals and local people via a structure of popular organization. The conceptualization envisaged two parallel, collaborative and mutually supportive structures which would lead to a far wider people's involvement and mobilization of local resources in support of health development. It would not be a competitive structure, but both sides would have an agreed upon role to play.

Structure of People's Participation in the Caranavi Health District

To achieve community participation, PHCT were formed at various levels. The PHCT's were supposed to perform the following functions :

- strengthen existing communal structures through planned development activities;
- develop a greater local critical consciousness of health issues;

- seek to improve the living conditions of local people and defend their interests; and
- support existing health services so that they function better.

The PHCT was regarded as essentially a people's organization, which would seek to involve people locally and would tackle local health problems. It was to be a representative and democratic body which would stress the value of communal actions and the joining of forces to tackle local health problems.

In reality, the PHCT in Caranavi Health District was a more complex structure than the people's Health Center, and little really was known about how well or in what ways it functioned. It would appear that there was no common pattern either of the tasks which PHCTs undertook nor of how they did function. PHCTs appear to range from the active to the sporadic and to the dormant and inactive. PHCTs in or nearer the towns or larger settlements were more active, while in many instances, little was known about what was happening in some of the more isolated settlements. In this respect, the health auxiliary of the health service system was a key figure; he or she had to get the PHCT going and the energies and the level of involvement of the health auxiliary had a direct influence upon the PHCTs in any health sector.

The key to the implementation of the Caranavi health development experiment was the People's Health Agent (PHA) . The PHA was a locally based health worker, selected by the community, trained by the District Health Service, equipped with the basic means to function and expected to serve as the community- based link between the Health Service and the people. The PHA was the symbol of participation, the democratization of the health service and the means by which people on a far wider basis could be brought within the ambit of health care. In terms of selection, it was suggested that a PHA should be literate, preferably young and with initiative, be willing to 'serve the community' and reside within it. In the earlier literature on the new health strategy, the basic functions of the PHA were seen as follows:

- promote the participation of the community in health activities;
- treat basic illnesses, with priority to mothers and children;
- seek to prevent diseases by means of health education;
- implement the district's health plans;
- maintain a supply of basic drugs and health equipment in the PHCs;
- undertake a local census;

- complete a monthly report on births and deaths.

Problems

The performances of PHAs in the health areas were subject to considerable variation and fluctuation. In each of the health areas, a hard core of original PHAs probably still exists, and these tend to be the more active ones. A widespread network of PHAs was set up quickly in 1986-87, but nobody had any substantial information as to what extent and how well it was still functioning. In discussions concerning problems associated with the performance of the PHAs, the following were mentioned:

- a continual lack of basic drugs, without which the PHA was unable to function or maintain credibility in the community;
- irregular or sporadic contact between health service staff and the PHA, which often results in a PHA simply ceasing to function;
- PHAs were often not linked to traditional medical care within the community and thus lacked support;
- some PHAs were closely linked to political structures within the community and selected on that basis;
- PHAs were usually literate and Spanish-speaking, while in the settlements, illiteracy was high and most people speak Aymara or Quechua;
- PHAs were trained as the last link in a vertical health service structure; inevitably they transmit this vertical authority to the villages in the way they deal with local people.

Critical Assessment

Given the general paucity of resources for district health development in Bolivia, the Caranavi experiment would never have got off the ground without support from the Pan-American Health Organization. This support was crucial, but unfortunately it has not been sustained. Caranavi showed, however, that with an initial external impetus and concentration of resources, experiments in health development could take hold and could quite quickly have a structural impact. At the time of this experiment, the district health service was the only development service which potentially reached even the most isolated settlements, and clearly it helped both to break their isolation and to integrate them into development activities.

Caranavi similarly demonstrated the clear link between district-level structures, which were seeking to promote people's involvement, and health service decentralization and

local autonomy. People's involvement must be built from the base upwards; it was not enough merely to proclaim it at the national level. In order to do this effectively at the district level, there must be some degree of local autonomy, control at the district level over health resources, and a district health service budget. In fact Caranavi had none of these facilities. Perhaps, the central problem here was the fact that the Caranavi experiment did not originate in the La Paz Health Unit ; it was largely isolated initiative and had no real institutional base in the Bolivian Health Service. Whatever the explanation, however, the experiment does suggest that the building of local level structures and the development of a health service in which people have a major role can best occur when district health services have some degree of local autonomy and when a district-based health budget exists. It is impossible for the health unit to develop and build upon local initiatives; this can only be done at the district level.

It is difficult to be sure what the notion of "participation" meant in the context of the Caranavi health experiment. The Health District and the experiment were born out of an ideological reappraisal of health and health development in Bolivia; but the actual practice had been far less radical. The notion of " participation" which emerged in Caranavi had largely been dictated by the availability of resources.

Finally, a lot has been learned about people's participation and district health services from Caranavi . By examining the three-year period and looking at the way in which participation developed, four stages can be identified:

1. initial contact : broadening the coverage of the health service;
2. active local involvement in specific health activities e.g. vaccination campaigns;
3. generating a more general interest in health development issues;
4. strengthening of the educational component of participation and development of more direct involvement in health service organization and management.

The practice, of course, was not as clear as the above, but certainly there were evidence of these different stages in several health areas. Some localities in Caranavi progressed to stages 1 and 2, albeit with varying degrees of sustainability. There were some initiatives around stage 3 in one or two sectors, largely built around the training of PHA. Stages 1 and 2 were the least difficult to achieve; stages 3 and 4 demanded more substantial support and appropriately trained staff.

Comilla Development Model, Bangladesh

The Comilla Development Model was a community development strategy popularly known as Comilla Approach (CA). This was developed at the then Pakistan Academy for Rural Development at Comilla, presently known as the Bangladesh Academy for Rural Development (BARD). The approach incorporated a two-tier system with cooperatives at the village level and a Thana Training and Development Centre (TTDC) as the focal point at the thana level. The approach was considered effective in its pilot phase and was replicated nationwide later through government systems with limited success.¹²

Goals

The major goals of the project included the following:

- make the villagers understand their problems best so that the village level workers (VLW) can learn from them and could explain the new approach;
- make the villagers capable of taking initiative for improving their condition through individual and cooperative action;
- create a capital followed by the provision for training and technical inputs, with an active participation of the villagers achieving the developmental process;
- encourage the villagers to organize themselves into cooperative groups;
- focus attention of income generating and directly productive activities with demonstration effects aiming at standards of living;
- provide technical and agricultural extension services;
- increase agriculture production and income-generating activities through provision of credit and technical inputs, training and extension services and improve marketing mechanism;
- develop Rural Works Programme (RWP) and Thana Irrigation Programme (TIP) in creating physical infrastructure and income generation;
- reduce costs and create managerial skills emphasizing local planning and participation of the local population;

¹² Chowdhury, A. N. 1990. Comilla development model. In A. N. Chowdhury, *Let Grass Roots Speak*, University Press Limited, Dhaka

- set up women's programme and family planning project and to start one-teacher village school.

Activities

A range of activities were included in the project. These were:

- increasing agricultural production and income-generating activities through provision of credit and technical inputs, training and extension services, and improved marketing mechanism;
- rural works programme including thana irrigation programme to create physical infrastructure and income generation;
- women's programme and family planning; and
- establishment of one-teacher schools.

Strategy

The implementation of the CA began with conducting meetings with the villagers at strategic geographical points to ensure maximum attendance to motivate the villagers to undertake changes, learn how to implement new ideas. Subsequently, villagers were brought to the academy for orientation and training. The village-level workers also lived in the villages to break the traditional socioeconomic barriers. The field officers were trained to enter into a 'friendly partnership' with the villagers'. The officers wished to be the helpers rather than administrators. The keynotes of this approach were collaboration and teamwork. Eventually, the villagers were encouraged to organize themselves into cooperative groups to start saving. Technical inputs for agricultural extension and credits were channelled through the cooperatives either to the group or to the individuals.

The villagers were the decision makers. Efforts were made to provide the villagers with institutional framework to make credit and other resource accessible. The villagers were expected to participate themselves in order to make the best use of the services offered. The project staff worked with the villagers through collaboration in the teamwork and were accountable to the representatives of the people in the local government bodies.

Organization

The village cooperative societies were designed to achieve the development of economic and functional efficiency. Their primary purpose was to remove agricultural production constraints and to diffuse modern technology. The model was based on primary cooperatives at village level working with a Thana Training and Development Centre with a well-built institutionalized infrastructure of Thana Central Cooperative Association.

Achievements

The programme demonstrated utmost potential for rural development. Some of the cooperatives made significant beneficial impact on the lives of the beneficiaries. Impressed by its success in Comilla, the model was replicated nationally as Integrated Rural Development Programme and later as Bangladesh Rural Development Board in the seventies.

Replication

The Bangladesh Rural Development Board (BRDB) implemented the Comilla Model of cooperatives nationally for the landless as BSS and the Mohilla Samiti for women as MSS. The BSS and MSS were set up during the middle of the Second Five-year Plan (SFYP) in 1983. Being recent institutions, the results of these schemes cannot be fully assessed. They are expected to provide support and services in terms of skill development, credit and input supply to the members for employment and income-generating activities in the allied farm and non-farm sectors.

About 77,000 BSS and 57,860 MSS have been organized with about 225,000 and 220,000 members respectively. At present, they are federated with the Upazila Central Cooperative Association(UCCA). Twenty non-farm income-generating activities have been selected for credit channelling to the distressed and landless groups. They are : pond fisheries, rice husking, goat rearing poultry raising, cattle fattening, rickshaw and rickshaw van, cane and bamboo works, cottage industry, bee-keeping, weaving, oil ghani, muri making, mat making, small trade, carpentry, pottery, kitchen gardening, sewing and garment making, livestock and milk production and mechanics.

The replication of the Comilla Model as Integrated Rural Development Programme (IRDP), later Bangladesh Rural Development Board (BRDB), in the seventies started with a setback. The new Government offered large scale highly subsidized agricultural inputs e.g. tubewells through Bangladesh Agricultural Development Corporation (BADC) without proper standards of selection. Needless to say, the agricultural assets were acquired by influential members of the cooperatives and local leaders. On paper, an irrigation fund or cooperative was set up which soon decided that the loans for the subsidized pumps need not be returned, and then treated the grants as free gifts. Funds for repair were not forthcoming; therefore, 50 percent of the tubewells soon fell into disuse due to lack of repair.

Furthermore, attempts on a national scale have never been made by a single agency to replicate the model in its entirety. Lacking a coordinated approach, the two-tier cooperative system, the Thana Training Development Centre, the Rural Works Programme (RWP) and Thana Irrigation Programme (TIP), pursued by the Ministry of Local Government, Rural Development and Cooperatives (MLGRDC), and without corresponding programmes in education and integrated extension services, the CM lost

much of its originality. The hopes raised by the RWP, the TIP and TTDC had not been fulfilled in later years either.

In spite of the best of intentions, BRDB provided more benefit to the land owners. The landless and marginal farmers who constituted about half of the rural population remained outside the mainstream of economic activities.

Sustainability

CA was not in a position to launch massive projects for the rural poor and landless although it was an agricultural growth-oriented programme. The establishment of Small Farmers Development Schemes and only a few cooperatives like *Deedar* had positive effects on small farmers and day labourers, including rickshaw pullers. Out of 400 cooperatives, only 61 were functioning. After 20 years most of the cooperatives failed to conduct weekly meetings, training, and follow-up. The lack of regular BARD supervision procedures had led to misuse of cooperatives and manipulation of the poorer members. The dishonesty of the cooperative members resulted in misuse of the cooperatives for procuring individual benefits.

Despite the above the concept of cooperatives developed through the Comilla Approach has resulted in many successful cooperative initiatives in the country. Most often succeeded were the ones with strong local initiatives and leadership which could negate the discouragement induced by large-scale extension under the governmental bureaucracy.

Chakaria Community Health Project (CCHP), Bangladesh

The Chakaria Community Health Project of the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B), has started in 1994 in Chakaria thana under Cox's Bazar district.¹³ The major objectives of the project have been to discover a strategy to ensure community participation in health matters and to assess the impact of such initiatives. The project has been trying to activate the existing indigenous village-based organizations (referred to as self-help organizations - SHO) to take initiatives for the improvement of health. Participatory research methods have been extensively used in carrying out the project activities. In its two years, the project made significant progress toward fulfilling its major objectives. The future challenges are to find ways to keep the initiatives of the village-based organizations sustained with minimum or no input from the project.

¹³ Bhuiya, A. 1996. Rethinking community participation. I :Prospects of health initiatives by indigenous self-help organizations in rural Bangladesh. Paper presented at the Fifth Annual Scientific Conference (ASCON V), International Centre for Diarrhoeal Disease Research, Bangladesh, Dhaka

Goal

- develop a strategy to ensure community participation in health matters and to improve health of the community members;
- measure the impact of the interventions on health.

Strategy

The project adopted the following strategies in implementing its activities.

- work only through indigenous village-based local organizations and bring health on their agenda;
- activate them to take health initiatives with own resources;
- promote preventive measures;
- provide technical assistance in health matters and organizational development;
- promote utilization of existing health facilities;
- utilize participatory methods in every aspect of project implementation such that community takes leadership and remain in control.

Financing

The project has been funded externally. However, the community initiatives have been funded by the village-based organizations with technical support from the project.

Achievements

During the first six months of the project, members of the staff were able to establish a confident relationship with the villagers. In the beginning, the female community organizers faced resistance from the villagers even to meet women which was significantly reduced after three to four months, and work could be carried out.

Representatives of the self-help organizations participated in health orientation sessions organized jointly by project staff and the self-help organizations. Action plans were developed by the SHOs to impart health education to the community members by volunteers both at the community and educational institutions.

So far, over 1000 volunteers (male female and student) have been nominated by the SHOs and neighbourhood clusters (in case of female volunteers). Most of them have

participated in training programmes organized by the project without receiving any material or cash incentives from the project. The school health volunteers communicate health messages to fellow students once a week for half an hour. The students also take the messages to their homes and share with other family members and immediate neighbours.

The male village health volunteers disseminate health messages in mosques during Friday prayers and in informal gatherings at tea stalls, and at other informal meeting places. The female volunteers disseminate health messages to women in nearby households.

In three villages, the self-help organizations have implemented, in collaboration with the government health authorities, a programme to control malaria by using impregnated mosquito bed nets. Despite discouragement by the project about curative services, the SHOs have established six village health posts with community resources. Village health care providers nominated by the SHOs and trained by the Government have been providing services in these health posts. Moreover, the government outreach services have started to take place in some of the village health posts on request from the SHOs.

Steps in Implementation

The following steps were involved in implementing the project activities:

1. Confidence relation building with the community through PRA;
2. Assessment of health problems through focus group discussion and individual discussion with key persons;
3. Arrange people's participatory planning sessions to identify problems, possible solutions, prepare action plan, implement and monitor the activities.

Organization of the Project

The project started with a team of six community organizers (3 female and 3 male), two self-help trainers, two applied social researchers, and a field team leader under the overall direction of a social scientist with technical assistance from an expatriate anthropologist throughout, a trainer at the beginning and a resident anthropologist at a later stage.

After a year of operation, one male and female public health physician and two paramedics have been added to mainly ensure the relevance and quality of health messages and to provide technical assistance in identifying effective solutions for solving prevalent health problems.

The community organizers have been responsible for establishing links with self-help organizations and community and for mobilizing them. The community health workers have been maintaining contact with the SHOs and gradually carrying out the work once

done by the community organizers. The applied social researchers were engaged in monitoring, evaluation, and providing feedback to the programme. The Field Team Leader is responsible for overall supervision in the field and maintaining links with Government and NGO activities in the locality.

Problems Encountered

While implementing the project, the following problems were faced:

- Relief mentality of the community members;
- Demand for curative service among the villagers;
- Traditional attitude of the villagers about women – unwilling to see women moving around;
- Anti-NGO sentiment of the villagers;
- Hatred against female NGO workers riding motor cycle.

Other problems included steering of the project personnel centering the project philosophy, maintaining the project philosophy in the face of the current trend of development with external resources, and responding to the needs of the community without creating a dependency relation between the community and the project.

Special Feature

One of the important strategies adopted in this project was to augment the agenda of the existing self-help organizations and activate them to take health initiatives. The project has been trying to participate in the endeavours taken by the SHOs rather than inviting villagers to participate in activities designed, implemented and managed by outside agencies,. The processes of relation building, needs assessment, health orientation, planning and implementation, were carried out in a participatory manner resulting in community involvement right from the beginning.

Sustainability

It is too early to comment on the prospect of sustainability of the initiatives taken by the SHOs. However, it is somewhat clear that the future continuation of the activities will largely depend on the sustainability of the village health posts in some form or the other.

Conclusion

It is evident from the literature review that various models have been utilized internationally to increase community participation and thereby long-term sustainability of project innovations. The eight most relevant projects reviewed above were from India, Kenya, Tanzania, Indonesia, Bolivia, and Bangladesh. The sectors involved in the development activities ranged from rural health to agricultural cooperatives. All had relevant national policies. A few attempted an urban focus on social mobilization.

Essentially, three models emerged: a small NGO working with a limited number of communities on a moderate range of complex issues (rural health and development activities); an international organization collaborating with local governments on a limited range of activities (e.g. nutrition); and a large public sector activity working on a complex set of issues (e.g. cooperatives and rural financing).

The nature of and opportunities for participation by the community in these projects ranged from membership in committees created by the projects, provision on voluntary labour, financial and/or material support to project activities, payment for services through local direction and management of the development activities. All of the projects began with initiatives from outside the community, and many were supported either politically or financially by national governments or donors ranging from local churches to multilateral UN agencies. Most of the projects documented community-involved development activities designed by outside experts or extension workers on the basis of their understanding of local needs. The less successful efforts utilized the community merely as the instruments of a national development scheme often with a plan to involve community following a top down approach.

Nevertheless, most successful projects used a process which took advantage of local structures, facilitated the utilization of local resources, either within the community or local NGOs and employed the systematic use of information for determining directions. This information often included community needs and interests as well as information on the feasibility of achieving benefits for the community from a particular development activity. One project (the Iringa Nutrition Project in Tanzania) described the process as a "triple A" system, as the decisions on local investments were made through local Assessment, participatory Analysis, and community Action.

Most of the projects had a long-term focus, that is generally over ten years and some as many as twenty years. Nevertheless, the community participation efforts documented in the literature described experiences gained during the project activities, and rarely talked about sustainability after the withdrawal of extra-community support. This is particularly critical for Bangladesh, where it is expected that the international support will be diminished with time and community financing efforts must increase.

An exception was a project in India (e.g. the Comprehensive Rural Health Project in Jamkhed, Ahmednagar District, Maharashtra State), which began withdrawing support after 17 years as many of the community organizations formed have become self-reliant. In case of the Karnataka project in India, the Family Planning Association of India also was able to reduce its contribution to local education and development activities within a five-year time frame by identifying other local NGOs who could be helpful in either keeping the project going or in expanding its range of activities, and by increasing the contribution of the communities' own resources. Nevertheless, it is unclear how well the activities are being carried out and how long these will sustain. The question of replication is also important and the Jamkhed project also did not indicate any strategy for replication.

Another relevant project is the ongoing Chakaria Community Health Project (CCHP) of ICCDR, B. This project is an example of the second model, that is an international organization collaborating with village-based indigenous organizations, referred to as self-help organization (SHO) to promote health, especially preventive measures. The approach has been participatory implying that the needs assessment, identification of solutions, planning and implementation of actions, and monitoring of the impact, have been done with the members of the indigenous organizations. The use of participatory research methodologies have been made extensively. The project in its third year could mobilize the community members and local resources to take initiatives for the improvement of health without material support from the project. Although the community enthusiasm and participation are apparent, long-term scenario is unclear.

One of the latest developments in the CCHP is the establishment of village health post (VHP) by the SHOs. Currently, village health care providers, nominated by the SHOs and trained by the government health authorities, have been providing free services in the village health posts on a part-time basis. SHOs have also been establishing link with the government health and family planning workers to provide services on the days of the monthly VHP sessions. With reference to the sustainability of the VHPs one way can be establishment of link with the government services, however, their growth will be dependent on the level of government supports and may suffer from similar constraints as that in the government facilities. It is obvious that the development of the VHPs will need financial and technical resources and quality of relevant services. Thus, a mechanism has to be found to generate resources for it is very likely that the future of these community initiatives can largely depend on their development in terms of quality and scope.

The replication of successful experiences in community participation is another problem area. The replication of the Comilla development model nationally through the government machinery in Bangladesh was, in fact, a major failure. In Bolivia, the community participation through peoples health committees to work side by side with the government system did not work. Thus in the context of community participation, two major challenges are: development of a model and then the possibility of its replication. Development of a model may be easier than replication because in most cases nationwide replication demands use of government system which in the past did not work in many

settings of the world. The less explored, however, have been the utilization of private sectors.

In conclusion, while community participation in any development activities -- be it health and family planning or any other sector is highly desirable. There are really a lack of appropriate models to ensure, replicate and sustain it. The prospect lies in using existing social capital as much as possible to ensure community participation and ingenuity in generating resources from the system for growth and expansion, perhaps through some kind of balance between the public and the private sectors.

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